South Sudan
2014CHF Standard Allocation Project Proposal

for CHF funding againstCRP2014

For further CHF information please visit http://unocha.org/south-sudan/financing/common-humanitarian-fund
or contact the CHF Technical Secretariatchfsouthsudan@un.org

This project proposal shall be submitted by cluster partners in two stagesto the Cluster Coordinators and Co-coordinators for each project against which CHF funds are sought. In the first stage, before cluster defenses, applying partners fill sections I and II. The project proposal should explain and justify the activities for which CHF funding is requested and is intended to supplement information already available in the CRP Project Sheets. The proposals will be used by the cluster Peer Review Team in prioritizing and selecting projects for CHF funding during CHF Standard Allocation round. Partners should also fill and submit to cluster coordinator/ co-coordinatorthe CHF ProjectSummary(Annex 1).In the second stage projects recommended for funding by the CHF Advisory Board must complete Section III of this application and revised/update sections I and II if needed.

SECTION I:

CRP Cluster	Nutrition

CHF Cluster Priorities for 2014 First Round Standard Allocation
This section should be filled by the cluster Coordinators/Co-coordinators before sending to cluster partners. It should provide a brief articulation of Cluster priority activities and geographic priorities that the cluster will recommend for funding from the CHFin line with the cluster objectiveshighlighted in the CRP 2014.

Cluster Priority Activities for this CHF Round

- Deliver quality, life-saving, management of acute malnutrition for at least 75 per cent of SAM cases and at least 60 per cent of MAM cases in all vulnerable groups, at both health facility and camp level, prioritising the 5 most affected states
- Provide access to programmespreventing malnutrition for at least 80 per cent of vulnerable people, at both health facility, community and camp level, prioritising the 5 most affected states
- Ensure enhanced needs analysis of the nutrition situation, and enhanced coordination and monitoring of the nutrition response

Cluster Geographic Prioritiesfor this CHF Round

1. Jonglei – all counties
2. Upper Nile – all counties
3. Unity – all counties
4. Central Equatoria – Juba (IDP camps)
5. Lakes- Awerial, Yirol West, Yirol East and Rumbek North
6. Warrap – Twc, Agok, Gogrial East, Tonj North, Tonj South and Tonj East

SECTION II

Project details
The sections from this point onwards are to be filled by the organization requesting CHF funding.

Requesting Organization
Comitato Collaborazione Medica

ProjectCRPCode	CRP Gender Code
SSD-14/H/60632	1

CRP Project Title*(please write exact name as in the CRP)*
Support the CHD in preventing and managing Acute Malnutrition among most vulnerable populations (boys and girls U5 and Pregnant and Lactating Women) of local and displaced communities in Awerial and Yirol East (Lakes) and Tonj East and Tonj South (Warrap) counties, through the integrated community-based approach at both health facility and camp level (IDP, POC).

Project Location(s)-list StateandCounty (payams when possible) where CHF activities will be implemented. If the project is covering more than one State please indicate percentage per State

State	%	*County/ies (include payam when possible)*
Warrap	60%	*Tonj East, Tonj South*
Lakes	40%	Awerial, Yirol East

Total Project Budget requested in the in South Sudan CRP	US$ 1,099,999
Total funding secured for theCRPproject ***(to date)***	US$160,369

Funding requested from CHF for this project proposal	US$350,000

Are some activities in this project proposal co-funded (including in-kind)? ☒Yes No ☐*(if yes, list the item and indicate the amount under column iof the budget sheet)*

Direct Beneficiaries*(Ensure the table below indicates both the total number of beneficiaries targeted in the CRPproject and number of targeted beneficiaries scaled appropriately to CHF request)*

	Number of direct beneficiaries targeted in CHF Project	Number of direct beneficiaries targeted in the CRP
Women:	14,830	29,660
Girls:	17,237	34,473
Men:	2,400	4,800
Boys:	14,103	28,206
Total:	**48,570**	**97,139**

Indirect Beneficiaries / Catchment Population (if applicable)

Target population is composed of communities living scattered, in remote/underserved areas and cattle camps, IDP/returnees' camps, with very poor or discontinuous access to basic services. U5 (59% of the beneficiaries) and women in reproductive age (approximately 38% of the beneficiaries, out of which at least 50% pregnant) are the most exposed to epidemic outbreaks and health complications due to low quality health care, poor health/nutrition education and hygienic conditions, men-driven RH decisions and delayed emergency response. Other MARPs categories include HIV+/TB patients and victims of inter-clan clashes. Nutrition prevention/raising awareness target mostly caretakers (including men) and opinion leaders (community/religious leaders, local institutions) to promote safe health, hygiene and sanitation behaviors (at least 13% of the beneficiaries). Indirect beneficiaries count around 441,000 people (70% of

		the population in the catchment area).

Targeted population: , IDPs, , Host communities,	**CHF Project Duration** (12 months max.,earliest starting date will beAllocationapprovaldate)

Implementing Partner/s (Indicate partner/s who will be sub-contracted if applicable and corresponding sub-grant amounts) n/a	Indicate number of months: 6 months **1 July – 31 December 2014**

Contactdetails Organization's Country Office	
Organization's Address	*CCM Office – Hai Thongping area, Plot 122, Block 3K South, 2nd Class Residential Area of Juba*
Project Focal Person	*Name, Email, telephone*
Country Director	*Elisabetta D'Agostino* *coutryrep.ssd@ccm-italia.org* *+211 918570727*
Finance Officer	*MekonnenAbegaz* *admin.ssd@ccm-italia.org* *+211 921899785*
Monitoring & Reporting focal person	*Elisabetta D'Agostino* *coutryrep.ssd@ccm-italia.org* *+211 918570727*

Contact details Organization'sHQ	
Organization's Address	CCM – Comitato Collaborazione Medica Via Ciriè 31/E 10152 Torino (Italy)
Desk officer	Daniela Gulino *daniela.gulino@ccm-italia.org* *Tel (+39) 011.6602793*
Finance Officer	Francesca Dal Maso *francesca.dalmaso@ccm-italia.org* *Tel (+39) 011.6602793*

A. Humanitarian Context Analysis

Briefly describe (inno more than300 words) the current humanitarian situation in the specific locations where CHF funded activities will be implemented. Provide evidence of needs by referencing assessments and key data, including the number and category of the affected population[1]

Awerial, Yirol East (Lakes),Tonj East and Tonj South (Warrap) Counties count 408,915[2] inhabitants (roughly 50% women, 50% men), 32,970 returnees (11,134 arrivals over the past 18 months)[3] and around 119,8974 IDPs, mostly resulting from the recent conflict. The already poor health and nutrition indicators of the target counties are aggravated by the conflict which is affecting the region. The livelihoods of millions of people have been grossly disrupted: crops have not been planted, livestock are dislocated and traders have fled - and with them the lifeline of commodities for local economies.
According to the South Sudan Response Plan (UN, June 2014) by August, some 4 million people will face acute food insecurity, i.e. a combined losses of access and availability of food, livelihood collapse and attendant malnutrition, morbidity and mortality between which about ¼ in Warrap State and Lakes State (respectively 745.000 and 543.000 people). Malnutrition rates have shot up, threatening the lives of tens of thousands of children. An estimated 223,000 will suffer from severe acute malnutrition. Poverty prevalence rate in the project counties stands at 48.9%, while maternal mortality is 2,054/100,000; neonatal mortality: 49/1,000; U5 mortality: 106/1,000.

In the last six months, due to the crisis that is afflicting some states and the consequent emergency, the **Warrap State** has lost good parts of the supporting funds for the nutrition activities. The current situation of a low level nutrition services integration in the Health system could have serious impact in the increases of GAM in the next future. Until January 2014 the nutrition services in Tonj East and Tonj South were delivered by WVI that in a pre- harvest survey reported respectively a U5MR of 1.42 and CMR of 0.82 and a U5MR of 1.96 and CMR of 0.48. In February 2014 WVI handed-over the services to CCM that in March carried-out an assessment to define the two counties needs and future plan. Unluckily after this first steps, it was not possible scaling-up the activities as planned because of the cancellation of the allocation of CHF Round 1 2014 one year nutrition projects. Moreover, the lack signature of PCA with UNICEF (due to a shortage of funds in the area), nutrition activities were limited to MUAC screening and referral services.From a WVI pre-harvest survey Tonj East and Tonj South are reported having a GAM 16.7% and SAM 4% (TS) and GAM at 19,2% and SAM at 3,3% in TE (2013), with 25,153 affected by severe acute malnutrition in TE and 19,522 in TS. This data risk to increase because of the poor services and the risk of acute food insecurity due to the reduced availability of food . In particular in Tonj East, the impact of the rainy season is so heavy on the road condition that many HFs risk to became inaccessible, with serious consequences to children and pregnant women because of the increment of malaria and diarrhea cases. Even the frequent cattle clash in the area, could contribute to the decrease of the health and nutrition condition of the Warrap population, reducing the mobility and accessibility to food and health services. For these reasons there is a urgent need to improve the nutrition services offered, the coordination within all the actors and improve the referral system.

In the **Lakes State** the nutrition needs have had a huge increment during the last months because of the displacement of thousands of people in the country, in particular in in Awerial county (*102,711 people estimated in May 2014).* The nutrition data, that were low thw WHO recommend standards (Awerial: a CCM SMART survey validated in May 2013 reported 21.1% GAM, 17.1% MAM and 4% SAM above the emergency threshold of GAM <15% established by WHO standards)have had a quickly further decrement because of the conflict raised up in December and the displacement of thousands of people. CCM has been working on Nutrition since September 2013, integrating MUAC screening and SAM management in the Child Health Care services of 11 PHCC/Us in Yirol East and Awerial counties. Recently, a Stabilization Centre has been established in Adior PHCC (in Yirol East county) to ensure the timely and proper management of complicated SAM cases. An effective collaboration with Plan International and the CHD, in

[1] To the extent possible reference needs assessment findings and include key data such as mortality and morbidity rates and nutritional status, and how the data differs among specific groups and/or geographic regions. Refer situation/data/indicators to national and/or global standards.

[2] South Sudan Census, 2008 with population growth (annual %) of 4.3% (http://data.worldbank.org/indicator/SP.POP.GROW)

[3] OCHA, data and statistics.

4 IPC, April 2014 (from the Nutrition Cluster Targets Estimation Prevalence)

Awerial and Yirol East County respectively, ensures the management of MAM cases upon the establishment of a simple referral system among partners. In the last week CCM as started to implement a SC in Mingkaman. In Awerial County, severely affected by the current emergency, CCM works in partnership with a number of health NGOs, promoting the timely and coordinated response to the humanitarian crisis. As for nutrition activities, to avoid overlapping of services and other resources, the H&N Cluster has decided to identify three partners for the management of key nutrition activities: i) Plan International is responsible for the management of MAM cases; ii) CCM has been identified as the only partner responsible of the management of SAM cases; and iii) MSF will admit and manage complicated SAMcases at SC level.

- In the other three target counties (Yirol East, Tonj East and Tonj South), as Leading Agency of the PHC service, CCM is the only the service provider appointed and responsible of the integration of Nutrition program within the PHC system.

There are the urgent needs to scale up the nutrition services in the project area:

- Food supplements provision)
- Provision of Vitamins and de-wormers;
- Education to the community on how to use balanced diets;
- Provision of supplementary food items.
- Strengthen the outreach
- Strengthen the referrals between OTP and TSFP implemented by the different organizations and ensure children receive appropriate treatment.
- Improve the quality and the services offered in the counties through the training of the OTP staff

B. Grant Request Justification

Briefly describe (inno more than300 words)the reasons for requesting CHF funding at this time. Explain how CHF funding will help address critical humanitarian gaps in your cluster.Explainthe value added by your organization (e.g. geographical presence). Indicate if any other steps have been taken to secure alternative funding.

In line with the Nutrition Cluster Strategy and Objectives, CCM aims at ensuring preventive and curative emergency nutrition services in the conflict-impacted counties of Awerial and Yirol East (Lakes State) and in Tonj East and Tonj South Counties of Warrap State, historically characterized by high levels of acute malnutrition and poor access to basic health services.

The Project is perfectly integrated with the following Cluster priority guidance:

- Scale-up a basic minimum package of nutrition interventions, for young children and P&LW which are both curative (screening and treatment of SAM and MAM) and preventative (IYCF promotion and support, micronutrient supplementation). Currently the **23 OTPs** and the **6 SCs** in the four counties are poorly staffed and missing equipment and supplies to provide qualitative nutrition services. The improvement of the nutrition staff skills through dedicated training and the on job training – thanks a new recruited nutrition expert – will allow CCM to improve both services and reporting on nutrition;.
- Enhance surveillance activities (rapid assessments, nutrition surveys, routine data analysis) to promote a clearer picture of the evolving nutrition situation and needs;
- Integrate nutrition activities into minimum basic health package and mobile health clinics, with MUAC screening, Vitamin A supplementation and de-worming into immunization campaigns;
- Ensure a coordinated response through national and state-level cluster coordination as well as with the other actors in the area;
- Strengthen State and County-level capacities to improve emergency response and preventive services.

As consequences of the HPF county-wide funding approach, CCM remains the CHD leading agency and the main Health providers in the four counties, responsible also for Nutrition program within PHC system.The current project will allow the partner to give continuity to what has been done up to now, to fully integrate the Nutrition activities in Yirol PHC system, Tonj East and Tonj South - where the nutrition services have been reduced as a consequence of lack of funds - and to respond to the humanitarian emergency need in Awerial County.The CHF funds are complementary to the funds provided by HPF - which doesn't cover the nutrition services, but will allow the partner to provide nutrition services close to the health ones, so that Nutrition activities will be integrated with MCH services, nutrition education within health education session and people accessing health facilities will benefit of nutrition services, while the communities will access to nutrition through outreaches. Again, CCM was recently awarded of an HPF fund to manage the Tonj Hospital, where CCM is running 1 SC, that will make it easier to empower and better integrate the nutrition services in the primary and secondary care in the county. The current project will also allow us to give continuity with the nutrition services CCM is delivering in the Lakes State and to fully implement the nutrition plan scale up developed in March for the two Warrap Counties and then left in standby because of the lack of appropriate support. The CHF will allow CCM to have more and better qualified resources in the field to implement the nutrition activities, train the health and OTP staff, collect the nutrition data and implement the needed survey and monitoring activities

In conclusion, CHF nutrition resources are crucial to complement CCM secured funds, covering financial gaps to manage and prevent acute malnutrition, such as:

- human resources,
- SC/OTP set up/reinforcement,
- expansion of outreach capacities,

Added values to the present proposal include:

- CCM long-standing partnership with SMoHs/CHDs
- integration of CHF project within broader programs;
- Prevention and treatment of SAM will be ensured through their integration into the basic package of health services provided at HFs level.

In order to reduce the number of defaulters registered in the first phase of the project, outreaches will be reinforced in order to:

- Identification and recording of the defaulters;
- talk to the mothers/families and understand the reasons for the choice (transport, lack of education);
- strengthen the education of the individual family;
- design a plan for ongoing support(weekly visit, for example)to reinforce the messages;

- identify a person to serve as community support and control over family.

C. Project Description(For CHF Component only)

i) Contribution to Cluster Priorities

Briefly describe how CHF funding will be used to contribute tothe achievement of the cluster priority activities identified for this allocation.

In line with the nutrition cluster objectives, CCM aims at ensure emergency nutrition services in 4 counties of Warrap State and Lakes State suffering from high malnutrition rates, poor access to basic health services, high influx of IDP and returnees.

The Project is perfectly integrated with the following Cluster priorities:

a) the **integrated management** of acute malnutrition in children under five, pregnant and lactating women, and other vulnerable groups;
b) the **prevention of malnutrition** in vulnerable population (pregnant and lactating women and children under five) through micronutrient supplementation, the provision of supplementary foods, support of infant and young child feeding, and health and nutrition education;
c) **strengthening of state and county-level coordination** aimed at improving emergency response and preventive services.

Besides CHF funds, CCM will rely on other supports, involving more donors and stakeholders and integrating this intervention in their wider programs to ensure a comprehensive answer to the assessed needs. CCM will continue engaging with other stakeholders on the ground to prevent overlapping and look for synergies to increase effectiveness of the program (namely Plan International for the referral of MAM cases in Awerial). UNICEF and WFP contribution in terms of food supplies for the treatment of SAM and MAM will be crucial. The proactive involvement of the local population, through the creating/strengthening of HCs (in which female participation will be encouraged), tasked with peer-to-peer education, will support the promotion of nutrition service and will enhance nutrition surveillance across the communities. Where present, also women's group shall be proactively involved in awareness-raising activities.

ii) Project Objective

State the objective/s of this CHF project and how it links to your CRP project (one specific geographical area, one set of activities or kickstart/support the overall project). Objective/s should be Specific, Measurable, Achievable, Relevant and Time-bound(SMART)

The project main objective is **to ensure access to preventive interventions and quality life-saving management services of Acute Malnutrition cases among children U5 and P&LW of local and displaced communities in four counties of Lakes and Warrap State.**
Under the stewardship of the CHDs, the strengthening of facility-based care and the active involvement of local communities, the action aims at:

- Promoting the MUAC screening of 100% of U5 children and P&LW at OPD and ANC/PNC level;
- Strengthening the identification and management capacity of SAM cases at OTP/SC level, promoting a recovery rate of at least 75%;
- Reinforcing the identification and management capacity of MAM cases, promoting their referral to partners already working in the target counties;
- Ensuring the access to micronutrients supplementation and de-worming services to at least 30% of U5 children and P&LW at OPD and ANC/PNC level;
- Capacitating facility-based and community-based health workers in the early identification and prompt management of acute malnutrition;
- Creating nutrition awareness among host, IDP and returnees communities.

For the objective and the identified expected outcomes, specific measurable indicators have been selected, most of which are indicated as Nutrition Cluster priorities and/or are MoH requirements for health reporting since relevant to achieve the HSDP 2012 – 2016 targets. The project timeframe (6 months) is adequate to meet the project objectives, since:
(i) implementing partner is already operating and have functioning field bases in each target county;
(ii) collaboration with institutional partners (Warrap and Lakes SMoH and concerned CHDs) for running integrated PHC and Nutrition services has been established and reinforced through the past several years.

iii) Project Strategy and proposed Activities

Present the project strategy (**what the project intends to do, and how it intends to do it).** There should be a logical flow to the strategy: activities should lead to the outputs, which should contribute towards the outcomes, which should ultimately lead to the project objective.
List the main activities and results to be implemented with CHF funding. As much as possible link activities to the exact location of the operation and the corresponding number of direct beneficiaries (broken down by age and gender to the extent possible).

The project strategy foresees:
(i) the treatment of SAM in accordance to the national protocols and guidelines, with a focus on strengthening linkages between MAM and SAM;
(ii) the provision of community-based services (including outreaches) in order to increase the accessibility of integrated health and nutrition services to remote communities, IDPs, vulnerable groups and MARP;
(iii) the elaboration of contingency/resilience plans to efficiently face nutrition-related emergencies;
(iv) the organization of targeted training sessions, in order to strengthen the management and planning capacities of the CHD officers.

SAM and MAM prevention and treatment will be ensured through its integration into the package of basic health services provided at HFs level and through the involvement of the community for the referral of cases. That will be possible improving HFs

conditions (infrastructures, equipment and supplies availability), training the local health staff and sensitizing/informing the population. The definition of a plan and of local synergies, together with actions specifically dedicated to nutrition data collection and analysis, will enable the local partners to monitor the catchment area nutrition status.
Moreover, the nutrition services delivery (as for outcomes 1) will contribute to the prevention of acute malnutrition in children under 5, P&LWs and other vulnerable groups and to the promotion of optimal health in infants and young children. The integration of the present project into the wider HPF intervention, that foresees the strengthening of the CHD and a consistent involvement of local communities in health system running, will positively influence the intervention impact and sustainability.

Output 1: **Quality life-saving management of acute malnutrition for SAM cases and MAM cases in all vulnerable populations (girls and boys under five years, pregnant and lactating women) in 23 OTP and 6 SC of Awerial, Yirol East, Tonj East and Tonj South counties, at both health facility and IDP camp level**

- Minor emergency rehabilitation of 6 SCs and 23 OTP;
- Maintaining of integrated ANC/PNC and nutrition services for P&LW (MUAC screening at PHCC/Us and IDPs level);
- Treatment of SAM cases in children U5 and vulnerable groups in OTP and SC;
- Enhancing the emergency referral system through improved coordination among stakeholders;
- Training of health workers on EPI, IMCI and trauma management integrated with nutrition services;
- Training of health workers on Integrated Management of Acute Malnutrition (IMAM) feeding for inpatient care;
- Training of health workers on Integrated Management of Acute Malnutrition (IMAM) therapeutic feeding for outpatient care;
- Training on identification and detection of Severe Acute malnutrition for CHWs, Nutrition assistant, community volunteers.

Output 2: **Promote access to interventions aimed at preventing malnutrition through the support of safe and appropriate infant and young child feeding practices and control of micronutrient deficiencies, at both health facility and camp level (IDP, POC), in the four target counties**

- Weekly education/screening outreaches, covering targeted counties, underserved areas, cattle camps, IDP/returnees camps;
- Micronutrients supplementation and de worming to P&LWs and U5 during ANC, EPI and consultation;
- Integrate U5 growth monitoring within EPI/OPD service provision;
- Weekly nutrition education sessions at facility/community level, targeting caretakers and women in childbearing age.
- Targeted education sessions on safe nutrition practices for opinion leaders, Village Health Committees, HHPs, religious leaders, community/cattle camps leaders.

Output 3: **Ensure enhanced needs analysis of nutrition situation, and coordination and monitoring of the nutrition response, through improved nutrition surveillance, reinforced monthly nutrition programme data collection and analysis and optimal nutrition cluster coordination**

- TA and supportive supervision to health staff responsible for nutrition data recording and drug administration;
- Coordination with other IPs and SMoH in counties, when SAM and MAM cases are treated by different partners.
- TA to CHDs and health staff on (i) MoH and Nutrition Cluster reporting, (ii) nutrition surveillance and e-warning systems;
- SMART Nutrition surveys in 2 counties;
- Scale up of joint CHD/implementing partners' supporting supervision of nutrition related performances;
- Effective participation to the Nutrition Cluster at state and national level;
- Facilitation of inter cluster coordination system.

Herewith the list of all sites of intervention:

County		**Name of site**	**SC**	**OTP**	**TSFP**	**BSFP**
Tonj East	1	Kacuat PHCU	X	X		
	2	Paweng PHCC		X		
	3	Ananatak PHCU		X		
	4	Wunlit		X		
	5	Makuach		X		
	6	Nabagok		X		
	7	Rumaborh		X		
Tonj South	8	Thiet PHCC	X	X		
	9	ManyielThony PHCU		X		
	10	PanakDitPHCU		X		
	11	MabiorYar		X		
	12	Tonj Hospital	X	X		
Yirol East	13	Adior PHCC	X	X	X	
	14	Nyang PHCC		X		

	15	Thonabuk-kok PHCU		X		
	16	Pagarau PHCU		X		
	17	Malek PHCU		X		
	18	Khap PHCU		X		
	19	Shambe PHCU		X		
Awerial	20	Bunagok PHCC	X	X		
	21	Awerial Centre PHCU		X		
	22	Mingkaman PHCU	X	X		
	23	Abuyung PHCU		X		
TOTAL			**6**	**23**	**1**	

iv) Expected Result(s)/Outcome(s)

Briefly describe the results you expect to achieve at the end of the CHF grant period.

Output 1: **Quality life-saving management of acute malnutrition for SAM cases and MAM cases in all vulnerable populations (girls and boys under five years, pregnant and lactating women) in 20 OTP and 4 SC of Awerial, Yirol East, Tonj East and Tonj South counties, at both health facility and IDP camp level**

DIRECT BENEFICIARIES OUTPUT 1:

- U5 SAM cases admitted for treatment: at least 2,888(50% girls);
- U5 MAM cases referred to partners for proper management: at least 5,350(50% girls);
- U5 supplemented with Vitamin A and de-wormed: at least 11,700 (50% girls).

Output 2: **Promote access to interventions aimed at preventing malnutrition through the support of safe and appropriate infant and young child feeding practices and control of micronutrient deficiencies, at both health facility and camp level (IDP, POC), in the four target counties**

DIRECT BENEFICIARIES OUTPUT 2:

- U5 screened (MUAC): at least 22807 (minimum 50% girls);
- Pregnant women receiving iron-folate: at least 2,730;
- Lactating women receiving Vitamin A: at least 2,730;
- Train Community Health Workers on prevention Detection and Management of Acute Malnutrition: 549 (27% women);
- Community members reached by nutrition messages (IYCF): at least 108.357(minimum 25% men).

Output 3: **Ensure enhanced needs analysis of nutrition situation, and coordination and monitoring of the nutrition response, through improved nutrition surveillance, reinforced monthly nutrition programme data collection and analysis and optimal nutrition cluster coordination**

DIRECT BENEFICIARIES OUTPUT 3:

- N. of CHD members assisted on nutrition surveillance, EP&R and monitoring: at least 8
- Number of joint supervision with the CHDs realized: 80%;
- No of pre/post harvest SMART surveys rapid nutrition assessment and surveillance conducted: at least 2;
- No of state level coordination meetings attended: 85%.

v)Listbelowthe output indicators you will use to measure the progress and achievement of your project results. Use a reasonable and measurable number of indicators and ensure that to the most possible extent chosen indicators aretaken from the cluster defined Standard Output Indicators (SOI) (annexed). Put a cross (x) in the first column to identify the cluster defined SOI. Indicate as well the total number of direct beneficiaries disaggregated by gender and age. Ensure these indicators are further used in the logframe.

SOI (X)	#	Standard Output Indicators (Ensure the output indicators are consistent with the output indicators that will be used in the results framework section III of this project proposal).	Target (indicate numbers or percentages) (Targets should be disaggregated by age and sex as per the standard output indicators list and add-up to the number of direct beneficiaries identified page 1)
xx	1	Children (under-5) admitted for the treatment of Severe Acute Malnutrition (SAM)	Male:1,501 Female:1,387
	2	Children (under-5) referred for the treatment of Moderate Acute Malnutrition (MAM)	Male: 2675 Female:2675
	3	No. of nutrition treatment sites	23
	4	No. of Stabilization centers	6
	5	No. of OTP sites	23
	6	No. of TSFP sites	1
		Pregnant women receiving iron-folate	2,730

	7		
	8	Lactating women receiving Vitamin A	2,730
	9	Health workers supported in Infant and Young Child Feeding (IYCF)	54 (27% women)

vi). Cross Cutting Issues

Briefly describe how cross-cutting issues (e.g. gender, environment, HIV/AIDS) are addressed in the project implementation.

DRR: Disaster risk reduction is mainstreamed in all project components by supporting basic nutrition services for children U5, PL&W both at facility and outreach level and by strengthening the nutrition EP&R of CHDs and selected Health/Nutrition staff.
In all the counties CCM will improve the provision of mobile clinic/outreach services to P&LW, children under 5 and other vulnerable groups including management of malnutrition and vaccination services. This activity includes, also: strengthen the ongoing EPI activities, MUAC screening with a particular focus on Mingkaman and other IDP settlements and in cattle camps in remote areas; support the CHD in the management of NID campaigns; strengthen/creation of Village Health Committees with male and female members and their involvement in the spreading of nutrition message and on the referral of cases.
ENVIRONMENT:PHCCs and PHCUs adhere to the infection control and universal precautions policies as it is recommended by the Ministry of Health and Public sanitation. Mitigation measures include: (i) incinerators for hazardous waste management are in use and periodically maintained in all CCM supported facilities; (ii) during outreaches, safe collection and waste dumping will be ensured; (iii) food preparation education sessions will mainstream environment education on the collection/use/management of cooking materials (charcoal/wood) (iv) vehicle movements will be effectively planned and coordinated in order duplications of trips to be avoided and several passengers from more stakeholders to be transported.
In all the counties CCM is working to improve the drugs management to reduce the % of expired drugs not used that need to be wasted. This activities will involve all the HFs staff as well as the Local authorities to spread the message that the HFs waste can have a really heavy impact on the environment and need to be reduced at the minimum.

HIV/AIDS: (i) nutrition surveillance and services will be fully integrated in the health system, including HIV/AIDS prevention promotion (availability of VCT/PMTCT services at hospital level), (iii) nutrition education sessions at both facility and outreach level will also address PMCTC (including infant breastfeeding for HIV+ mother), nutrition requirements for people living with HIV&AIDS, and HIV prevention (within FP education).

GENDER: The current M&E data collection tools we use in all departments disaggregate gender into female and male and by age. The health and nutrition services are provided by female health staff to demonstrate women involvement in decision making in a male dominated community. Some other action promoted to improve the gender issues are the following: (i) equal opportunity of accessing health services are ensured to both male and female patients; (ii) mobile clinic services in the most remote areas and critical contexts (returnees and IDPs camps) will facilitate women in accessing health care, as they are usually penalized by HFs distance because of their home care duties and of some traditional rules regulating their movements. Moreover, women will play a great role in the successful implementation of the project activities through the active participation of the female health staff in nutrition activities, including outreach and health education sessions. Through the project implementation period, CCM will embrace the following actions to achieve gender balance:
(i) promotion of female candidatures to fill in vacant positions. During outreaches, female staff will be encouraged to give nutrition education to clear the notion that women are not suppose to be involve major decision making in a community gatherings or meetings
(ii) promotion of FP for couples. Child bearing is a responsibility of both couple therefore CCM in it's strategy tries to involve couple couselling for the new family planning users though the acceptance rate is still very low
(iii) increase the collection of disaggregated data by gender and age.
CAPACITY DEVELOPMENT;: To improve the capacity building activities CCM is recruiting new qualified staff that could assist the field and local staff with both theoretical and on the job trainings, involving both nutrition personnel and institutional partners. The capacity building and local staff empowering have been included as main project activities to concretely enforce the early warning and nutrition emergency risk reduction in Warrap and Lakes State and ensure adequate sustainability to the project. The identified implementation modalities (see below) envisage and pursue full and active involvement of the institutional stakeholder in the project follow up and consistent monitoring, as well as in the regular info and data sharing with other stakeholders to better coordinate emergency response and manage integrated resources.

vii) Implementation Mechanism

Describe planned mechanisms for implementation of the project. Explain if it is implemented through implementing partners such as NGOs, government actors, or other outside contractors.

Project implementing partners is the INGO CCM (Comitato Collaborazione Medica), Warrap and Lakes SMoH partner for health care service provision in Tonj East/Tonj South and Awerial/Yirol East counties. CCM has an operational MoU signed with concerned SMoH for supporting the provision of integrated primary/secondary health care and nutrition services in both catchment areas. Strengthening local health system through collaboration with stakeholders and researching for synergies, preventing duplications or establishment of parallel health/nutrition structures, are CCM pillars in program planning and implementation. CCM is registered INGO in SS and acknowledged also by the national MoH. At local level, smooth collaboration with CHD and other local institutions (Counties Manager, RRC Office, Commissioner, etc.) is already in place.

CCM ensures adequate support and supervision to integrated PHC & Nutrition service delivery and emergency response in all Greater Yirol and in Tonj East and South. Outreaches, support to the existing SC and OTP and enforcement of effective referral system at state level are meant at widening population access to and utilization of frontline and emergency nutrition services, as well as to expand the nutrition surveillance capacities.
The project design is based on sound collaboration among CCM, health institutions at state and county level, other stakeholders (UNICEF, WFP, other INGOs and CBOs). To scale up the nutrition services in Tonj East and Tonj, proceed with the integration of

the nutrition activities in Yirol East and Awerial as well as to give the right response to emergency in Mingkaman CCM as recruited two more nutrition expert that will have the task to implement and monitor the CCM nutrition activities. Again to have a better data collecting and evaluation system CCM is recruiting a experiences Health Advisor with good skill also on nutrition and ICCM, to fully integrate the nutrition services in the the County Health System. The Health Advisor, in cooperation with the Nutrition expert will have also the task to define the training plan, standardize the tools and the methodologies as well as to evaluate their impact.

In order to ensure proper coordination, adherence to the activity plan and capacity of prompt project adjustments (when required), 2 project coordination bodies will be purposely established and meet on regular basis to ensure achievement of expected results:

- MANAGEMENT COMMITTEE (one per county): Composed of CHDs Manager and CCM Project Managers, the MC will meet on monthly basis in each county and will be responsible for: (i) defining/consolidating/readjusting the work plan, (ii) sharing information and data on the activities carried out and in pipeline, (iii) debating possible project implementation challenges and identifying the related way forward, (iv) providing technical assistance in the project supervision, (v) consolidating quarterly project reports, (vi) representing the Project board in front of local stakeholders and when project-related decisions are taken.
- STEERING COMMITTEE (one per State): Composed of Lakes and Warrap State MoH DG (or his/her delegate), CCM Country Representative in South Sudan (or his/her delegate), the SC will meet on quarterly basis and will be responsible for: (i) supervising the general project implementation and provide related feedback/advice to the Management Committee, (ii) facilitating integration of the project with other health activities in the catchment areas, (iii) linking with other stakeholders at federal and state level (Nutrition & Health Clusters, WaSH clusters, UNFPA, WHO, UNICEF, other INGOs, etc.) to facilitate the project implementation and promotion. CCM is currently receiving nutrition supplies from UNICEF and some drugs supplies for emergency in Mingkaman from WHO. In Awerial and YIrol East the referring partners for MAM cases is Plan, while in Tonj East and Tonj South it is actually WVI.From the original agreement with WVI CCM is supposed to take care of the TSFP activities in the two Warrap counties within the hand of the year to complete the nutrition handover from WVI. For these reason we are submit an agreement to the WFP in the next months.
- The wider cooperation IPs are creating with the CHD of the targeted Counties (TA, co-location, regular meetings…) will be functional to ensure project implementation and reorientation in line with the local needs and constant monitoring and evaluation.
- In all the 4 counties, as county health leading agency, CCM is working in strict cooperation with the CHD to improve the coordination of all the actors working in the health and nutrition sectors in the area. In this role CCM will be also responsible to support the CHD in the collecting of health and nutrition data from all the partners in the counties and to share them with the SMoH and the main SMoH partners and donors.

viii) Monitoring and Reporting Plan

Describe how you will monitor and report on the progress and achievements of the project. Notably:

1. Explain how will you measure whether a) Activities have been conducted, b) Results have been achieved, c) Cross-cutting issues have been addressed, and d) Project objectives have been met.
2. Indicate what are the monitoring institutional arrangements (e.g. monitoring team, monitoring schedule, updates to management etc.) and monitoring tools and technics will be used to collect data on the indicators to monitor the progress towards the results achieved. Please provide an indication of the frequency data will be collected and if there is already a baseline for the indicators or if a baseline will be collected.
3. Describe how you will analyze the data collected and report on the project achievements in comparison with the project strategy.
4. Ensure key monitoring and reporting activities are included in the project workplan (Section III)[5].

CCM shall ensure continuous monitoring of project activities by:

- EFFECTIVE REPORTING SYSTEM: (i) compilation of daily/weekly/monthly health facility registers, (ii) compilation of outreach reports, (iii) compilation of monthly and quarterly reports for concerned CHDs and State MoH (Nutrition Cluster reporting tools), (iv) compilation of quarterly progress report for the SC and the donors, (v) monthly and quarterly reports to HQ project department. With regard to data collection and analysis, utilization of DHIS shall ensure integration of project data within the MoH reporting system. Monthly reports to the national Nutrition Cluster shall be timely submitted.
- QUALIFIED TECHNICAL ASSISTANCE: both implementing partners have envisaged employment of technical human resources skilled in Nutrition program management and supervision, responsible for assisting local health staff at both facility and outreach level. They will be based in each main project location and will ensure daily supervision of the quality of the services provided and consistency of data collected.
- M&E OFFICER: CCM staff includes M&E officer based in SS Head Office (Juba), who will be responsible of periodic visits in the project areas, to check about indicators, targets and performances.
- EXTERNAL MONITORING: implementing partners will share periodical information and data on the project implementation with Health Cluster focal persons both at State and federal level, to compare views and get additional inputs and comments.
- STEERING COMMITTEE & MANAGEMENT COMMITTEE: among the SC ToR, supportive supervision and technical assistance to the MC throughout the project implementation is included. The MC shall utilize the project logical framework and work plan as primary tools to assess project performances, achieved versus expected results/targets and respect of the timeframe. IPs and concerned CHDs shall start having regular planning meeting, both internal and with the PHCUs and the VHCs. Data coming from project M&E will inform the discussion, providing the base to define further interventions to address nutrition problems or to re orientate the ones on going. Project report data will be also used to brief the State authorities on County situation, supporting a wider decision-making process on the steps to be done to improve people Health and Nutrition status.
- EFFECTIVE FINANCIAL MONITORING SYSTEM: (i) CCM accounting system are based on the double-entry system, which records transactions into journals and ledgers. Daily transactions, including purchases, cash receipts, accounts

[5]CHF minimum narrative reporting requirements will include the submission of a final narrative report and where applicable a narrative mid-term report. Narrative reports will include a progress on the project achievements using theoutputs indicators listed in this project proposal.

receivable and accounts payable are recorded using a specific accounting software which is reconcile on a weekly/monthly basis under the supervision of HQ administrative department; budget follow-up are elaborated and approved by HQ project department together with the request for funds (ii) procurement plan is elaborated at the begin of the project and review on a quarterly basis with the support and supervision of HQ procurement officer; (iii) compilation of financial report is elaborated by CCM Country Administration with the support of a Project Accountant and subsequently approved by HQ administrative department.

D. Total funding secured for theCRPproject
Please add details of secured funds from other sources for the project in the CRP.

Source/donor and date (month, year)	**Amount** (USD)
CHF 2014 – Round 1	160,369 USD
Pledges for the CRP project	
HPF (1/11/2013 – 31/12/2016)	28,527 USD
UNICEF (15/06/2014 – 14/06/2015), not yet confirmed	42,053 USD
UNICEF in kind, not yet confirmed	366,851 USD

SECTION III:

This section is NOT required at the first submission of a proposal to the cluster coordinator/co-coordinator. However it is required to be filled for proposals recommended for funding by the Advisory Board.

The logical framework is a tool to present how the implementation of CHF funded activities and their results (outputs and outcomes) will contribute to achieving higher level humanitarian results (project and cluster objectives) and how these results will be measured.

Fill in the logical framework below for this project proposal ensuringthe information provided is in accordance with the strategies and activities described in the narrative section of this proposal, in particular section C. Follow the guidance and the structure (Goal, objective, outcome, outputs and activities) and the numbering. Add/remove lines according to the project strategy.

LOGICAL FRAMEWORK		
CHF ref./CRP Code: SSD-14/H/60632	**Project title:** Support the CHD in preventing and managing Acute Malnutrition among most vulnerable populations (boys and girls U5 and Pregnant and Lactating Women) of local and displaced communities in Awerial and Yirol East (Lakes) and Tonj East and Tonj South (Warrap) counties, through the integrated community-based approach at both health facility and camp level (IDP, POC).	**Organisation:** **CCM**

Goal/Objectives/Outcomes/Outputs		**Indicator of progress**	**Means of Verification**	**Assumptions and Risks**
Goal/Impact (cluster priorities)	**Management of Acute malnutrition** Treatment of acute malnutrition in children U5 years, P&LW and other vulnerable groups with focus on strengthening linkages of programme activities for SAM and MAM. This will also include management of essential nutrition supplies from procurement to end user location **Prevention of Acute Malnutrition** During lean seasons, supplementary foods to (BSFP) to boys and girls aged 6-36 months. Promotion of optimal infant and you child feeding in emergencies. **Provision of Emergency preparedness and response services** Investing in the skills to conduct rapid assessments and to conduct nutrition surveys to determine the prevalence of malnutrition is selected counties.	- U5 SAM cases treated - U5 MAM cases treated - U5 supplemented with Vitamin A and de-wormed - P&LW and U5 supplemented with macronutrients - Health staff trained/supervised on Nutrition related topics - U5 screened (MUAC) - P&LW screened (MUAC) - Community members reached by nutrition messages (IYCF)	- Consolidated official nutrition data; - Monthly Nutrition Report; - Others data sources (OCHA, IOM, etc.)	•Internal and cross-borders political stability; • Institutional willingness to effectively target nutrition emergencies; • No movement restrictions for implementing partners • Conductive weather conditions The CHD are fully staffed and committed to improve their capacity and skills. • WS and LS MoH policy supports the integration of nutrition services within the primary and secondary Health care • Local communities, IDPs and returnees do acknowledge and are willing to access/utilize frontline nutrition services •The CHD are fully staffed and committed to improve their capacity and skills.
CHF project Objective	The project main objective is to ensure access to preventive interventions and quality life-saving management services of Acute Malnutrition cases among children U5 and P&LW of local and displaced communities in four counties of Lakes and Warrap State. Under the stewardship of the CHDs, the strengthening of facility-based			

Goal/Objectives/Outcomes/Outputs		Indicator of progress	Means of Verification	Assumptions and Risks
	care and the active involvement of local communities, the action aims at:			
Outcome 1	• Promoting the MUAC screening of 100% of U5 children and P&LW at OPD and ANC/PNC level; • Strengthening the identification and management capacity of SAM cases at OTP/SC level, promoting a recovery rate of at least 75%; • Reinforcing the identification and management capacity of MAM cases, promoting their referral to partners already working in the target counties; • Ensuring the access to micronutrients supplementation and de-worming services to at least 30% of U5 children and P&LW at OPD and ANC/PNC level; • Capacitating facility-based and community-based health workers in the early identification and prompt management of acute malnutrition; • Creating nutrition awareness among host, IDP and returnees communities.	• U5 screened (MUAC): at least 11,700(minimum 50% girls); • Pregnant women receiving iron-folate: at least 2,730; • Lactating women receiving Vitamin A: at least 2,730; • Health workers supervised in IYCF: 99 (27% women); • Community members reached by nutrition messages (IYCF): at least 14,500(minimum 25% men). • U5 SAM cases admitted for treatment: at least 2,296 (50% girls); • U5 MAM cases admitted for management: at least 594 (50% girls); • U5 MAM cases referred to partners for proper management: at least 5,350 (50% girls); • U5 supplemented with Vitamin A and de-wormed: at least 11,700 (50% girls). • N. of CHD members assisted on nutrition surveillance, EP&R and monitoring: at least 8 • Number of joint supervision with the CHDs realized: 80%; • No of pre/post harvest SMART surveys rapid nutrition assessment and surveillance conducted: at least 2; • No of state level coordination meetings attended: 85%	• Weekly nutrition reports; • Monthly nutrition reports • SC/OTP registers; • Community activities reports; • Drugs consumption reports; • Joint monthly supervision reports. • State coordination meetings minutes; • OTP/SC visits registers • SMART Surveys results and final report; • Consolidated official nutrition data; • Other data sources (OCHA, IOM, etc.)	•Internal and cross-borders political stability; • Institutional willingness to effectively target nutrition emergencies; • No movement restrictions for implementing partners • Conductive weather conditions The CHD are fully staffed and committed to improve their capacity and skills. • WS and LS MoH policy supports the integration of nutrition services within the primary and secondary Health care • Local communities, IDPs and returnees do acknowledge and are willing to access/utilize frontline nutrition services •The CHD are fully staffed and committed to improve their capacity and skills.
Output 1.1	Output 1: Quality life-saving management of acute malnutrition for SAM cases and MAM cases in all vulnerable populations (girls and boys under five years, pregnant and lactating women) in 20 OTP and 4 SC of Awerial, Yirol East, Tonj East and Tonj South counties, at both health facility and IDP camp level	• Number of U5 SAM cases admitted for treatment: at least 2,888(50% girls); • Number of U5 MAM cases referred to partners for proper management: at least 5,350(50% girls); Number of U5 supplemented with Vitamin A and de-wormed: at least 11,700 (50% girls).	• Weekly nutrition reports; • Monthly nutrition reports • SC/OTP registers; • Community activities reports; • Drugs consumption reports; Joint monthly supervision reports.	• The CHD are fully staffed and committed to improve their capacity and skills. • WS and LS MoH policy supports the integration of nutrition services within the primary and secondary Health care • Local communities, IDPs and returnees do acknowledge and are willing to access/utilize frontline nutrition services; • Internal and cross-borders political stability;
Activity 1.1.1	Minor emergency rehabilitation of 6 SCs and 23 OTP;			

Goal/Objectives/Outcomes/Outputs		Indicator of progress	Means of Verification	Assumptions and Risks
Activity 1.1.2	Maintaining of integrated ANC/PNC and nutrition services for P&LW (MUAC screening at PHCC/Us and IDPs level);			
Activity 1.1.3	Treatment of SAM cases in children U5 and vulnerable groups in OTP and SC;			
Activity 1.1.4	Enhancing the emergency referral system through improved coordination among stakeholders;			
Activity 1.1.5	Training of health workers on EPI, IMCI and trauma management integrated with nutrition services;			
Activity 1.1.6	Training of health workers on Integrated Management of Acute Malnutrition (IMAM) feeding for inpatient care;			
Activity 1.1.7	Training of health workers on Integrated Management of Acute Malnutrition (IMAM) therapeutic feeding for outpatient care;			
Activity 1.1.8	Training on identification and detection of Severe Acute malnutrition for CHWs, Nutrition assistant, community volunteers.			
Output 1.2	Output 2: Promote access to interventions aimed at preventing malnutrition through the support of safe and appropriate infant and young child feeding practices and control of micronutrient deficiencies, at both health facility and camp level (IDP, POC), in the four target counties	• Number of U5 screened (MUAC): at least 22807 (minimum 50% girls); • Number of Pregnant women receiving iron-folate: at least 2,730; • Number of Lactating women receiving Vitamin A: at least 2,730; • Number of Community Health Workers trained on prevention Detection and Management of Acute Mlanutrition: 549 (27% women); • Number of Community members reached by nutrition messages (IYCF): at least 108.357(minimum 25% men).	• Weekly nutrition reports; • Monthly nutrition reports • SC/OTP registers; • Community activities reports; • Drugs consumption reports; • Joint monthly supervision reports.	• The CHD are fully staffed and committed to improve their capacity and skills. • WS and LS MoH policy supports the integration of nutrition services within the primary and secondary Health care • Local communities, IDPs and returnees do acknowledge and are willing to access/utilize frontline nutrition services • Internal and cross-borders political stability;
Activity 1.2.1	Weekly education/screening outreaches, covering targeted counties, underserved areas, cattle camps, IDP/returnees camps;			
Activity 1.2.2	Micronutrients supplementation and de worming to P&LWs and U5 during ANC, EPI and consultation;			
Activity 1.2.3	Integrate U5 growth monitoring within EPI/OPD service provision;			
Activity 1.2.4	Weekly nutrition education sessions at facility/community level, targeting caretakers and women in childbearing age.			
Activity 1.2.5	Targeted education sessions on safe nutrition practices for opinion leaders, Village Health Committees, HHPs, religious leaders, community/cattle camps leaders.			
Output 1.3	Output 3: Ensure enhanced needs analysis of nutrition situation, and coordination and monitoring of the nutrition response, through improved nutrition surveillance, reinforced monthly nutrition programme data collection and analysis and optimal nutrition cluster coordination	• N. of CHD members assisted on nutrition surveillance, EP&R and monitoring: at least 8 • Number of joint supervision with the CHDs realized: 80%; • No of pre/post harvest SMART surveys rapid nutrition assessment and surveillance conducted: at least 2; • No of state level coordination meetings attended: 85%.	• Joint supervisions reports; • State coordination meetings minutes; • Survey report; • OTP/SC visits registers.	• The CHD are fully staffed and committed to improve their capacity and skills. • Internal and cross-borders political stability;
Activity 1.3.1	TA and supportive supervision to health staff responsible for nutrition data recording and drug administration;			
Activity 1.3.2	Coordination with other IPs and SMoH in counties, when SAM and MAM cases are treated by different partners.			
Activity 1.3.3	TA to CHDs and health staff on (i) MoH and Nutrition Cluster reporting, (ii) nutrition surveillance and e-warning systems;			
Activity 1.3.4	SMART Nutrition surveys in 2 counties;			
Activity 1.3.5	Scale up of joint CHD/implementing partners' supporting supervision of nutrition related performances;			
Activity 1.3.6	Effective participation to the Nutrition Cluster at state and national level;			
Activity 1.3.7	Facilitation of inter cluster coordination system.			

PROJECT WORK PLAN

This section must include a workplan with clear indication of the specific timeline for each main activity and sub-activity (if applicable).
The workplan must be outlined with reference to the quarters of the calendar year. Please insert as well the key monitoring activities to be conducted during the project implementation (collection of baseline, monitoring visits, surveys etc.)

Project start date:	**1 July 2014**	**Project end date:**	**31 December 2014**

Activities	**Q2**	**Q3/2014**			**Q4/2014**		
	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Output 1: Quality life-saving management of acute malnutrition for SAM cases and MAM cases in all vulnerable populations (girls and boys under five years, pregnant and lactating women) in 20 OTP and 4 SC of Awerial, Yirol East, Tonj East and Tonj South counties, at both health facility and IDP camp level							
1.1.1 Minor emergency rehabilitation of 6 SCs and 23 OTP;		X	X	X	X	X	X
1.1.2 Maintaining of integrated ANC/PNC and nutrition services for P&LW (MUAC screening at PHCC/Us and IDPs level);			X	X	X	X	X
1.1.3 Treatment of SAM cases in children U5 and vulnerable groups in OTP and SC;			X	X	X	X	X
1.1.4 Enhancing the emergency referral system through improved coordination among stakeholders;		X	X	X	X	X	X
1.1.5 Training of health workers on EPI, IMCI and trauma management integrated with nutrition services;					X		
1.1.6 Training of health workers on Integrated Management of Acute Malnutrition (IMAM) feeding for inpatient care;			X				
1.1.7 Training of health workers on Integrated Management of Acute Malnutrition (IMAM) therapeutic feeding for outpatient care;			X				
1.1.8 Training on identification and detection of Severe Acute malnutrition for CHWs, Nutrition assistant, community volunteers.			X				
Output 2: Promote access to interventions aimed at preventing malnutrition through the support of safe and appropriate infant and young child feeding practices and control of micronutrient deficiencies, at both health facility and camp level (IDP, POC), in the four target counties							
1.2.1 Weekly education/screening outreaches, covering targeted counties, underserved areas, cattle camps, IDP/returnees camps;		X	X	X	X	X	X
1.2.2 Micronutrients supplementation and de worming to P&LWs and U5 during ANC, EPI and consultation;		X	X	X	X	X	X
1.2.3 Integrate U5 growth monitoring within EPI/OPD service provision;		X	X	X	X	X	X
1.2.4 Weekly nutrition education sessions at facility/community level, targeting caretakers and women in childbearing age.		X	X	X	X	X	X
1.2.5 Targeted education sessions on safe nutrition practices for opinion leaders, Village Health Committees, HHPs, religious leaders, community/cattle camps leaders.			X	X	X	X	X
Output 3: Ensure enhanced needs analysis of nutrition situation, and coordination and monitoring of the nutrition response, through improved nutrition surveillance, reinforced monthly nutrition programme data collection and analysis and optimal nutrition cluster coordination							
1.3.1 TA and supportive supervision to health staff responsible for nutrition data recording and drug administration;		X	X	X	X	X	X
1.3.2 Coordination with other IPs and SMoH in counties, when SAM and MAM cases are treated by different partners.			X		X		X
1.3.3 TA to CHDs and health staff on (i) MoH and Nutrition Cluster reporting, (ii) nutrition surveillance and e-warning systems;		X	X	X	X	X	X
1.3.4 SMART Nutrition surveys in 2 counties;						X	X
1.3.5 Scale up of joint CHD/implementing partners' supporting supervision of nutrition related performances;		X	X	X	X	X	X
1.3.6 Effective participation to the Nutrition Cluster at state and national level;		X	X	X	X	X	X
1.3.7 Facilitation of inter cluster coordination system.		X	X	X	X	X	X
MONITORING AND REPORTING ACTIVITIES							
Weekly nutrition report		X	X	X	X	X	X
Monthly nutrition report		X	X	X	X	X	X
Final Nutrition Report							
Monthly Joint supervision		X	X	X	X	X	X
Nutrition expert monitoring report (1 each county)			X	X		X	X
CHD monthly meeting minute		X	X	X	X	X	X

*: TIMELINE FOR EACH SPECIFIC ACTIVITY MUST BE MARKED WITH AN XAND SHADED GREY 15%